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“The worst thing I’ve ever experienced” – comparing experiences of affirmative and non-affirmative healthcare provision for trans adolescents in the UK

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Abstract

Background

Within trans youth healthcare two fundamentally different models of care persist, with a significant difference between affirmative and non-affirmative healthcare services. To date there has been limited lived-experience-centred research contrasting child and family perspectives on affirmative and non-affirmative services from those with experience in both approaches.

Aims

This article examines trans adolescent and family experiences in affirmative and non-affirmative healthcare services in the UK.

Methods

20 semi-structured interviews were conducted with parents/carers (14) and adolescents (6) on their experiences in non-affirmative NHS gender clinics and in affirmative NHS primary healthcare and private sector provision in the UK. All interviewees had experienced at least one affirmative provider; 10 parent/carer interviewees and four adolescent interviewees had experienced at least one non-affirmative provider. Data were analyzed through reflexive thematic analysis.

Results

The research highlighted three significant differences between affirmative and non-affirmative care, related to identity probing, uncomfortable questioning, and asserting power.

Discussion

This article provides lived experience perspectives on the harms and failings in non-affirmative healthcare provision in NHS children's gender clinics in the UK. It also provides lived experience insight on the benefits and strengths of affirmative healthcare provision, that were unanimously desired and found beneficial by those interviewed.

Implications

This article provides insights that should be of interest to those designing and delivering healthcare services. It also provides insights to help potential service users, especially trans children and young people, better understand the challenges, harms, and risks inherent in non-affirmative healthcare.

Keywords
Children, parent, qualitative research, transgender

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Introduction

Within trans child and adolescent healthcare there are two distinct models of care, affirmative and non-affirmative services, distinguished by differing approaches to childhood transness (Hidalgo et al., 2013). Gender affirming services ascribe to a fundamental principle "that every individual should have the right to live in the gender that is most authentic to them" (Ehrensaft, 2021, p. 287). Gender affirming services avoid pathologising approaches that problematize, probe, challenge or question a person's identity, rejecting any need to establish "whether clients are "truly trans" (Fraser et al., 2021, p. 454). Affirmative services embrace transness at any age as a healthy and non-pathological part of human diversity, without presuming that transness necessitates investigation or explanation, and while respecting a trans child as the authority on their own identity and healthcare needs (Telfer et al., 2018). In contrast, services that are not overtly affirmative (here on described as 'non-affirmative' services) regard transness, especially in childhood, with skepticism, 'caution' or hostility (Ashley, 2019a). Non-affirmative services typically emphasize clinician authority in determining the validity of a trans identity, in ruling out alternative diagnoses, and in examining possible negative influences or causes of what is treated as a sub-optimal gender pathway. Non-affirmative services are inherently conversive in practice, putting a trans child's identity under clinical scrutiny in ways that overtly or covertly communicate a message that being trans is a problem (Ashley, 2022).

Lived experience perspectives on different models of care

Trans healthcare services have historically been associated with

abusive and authoritarian practices that fail to center patient autonomy and well-being (Ansara & Hegarty, 2012; Jacobsen, 2024). Through the second half of the twentieth century, gender clinics across Europe and North America operated to gatekeep access to trans healthcare, controlling and limiting access to social, legal and medical transition (Ashley, 2019a; Pearce, 2018). Pathologising healthcare services put in place elaborate processes and phases of assessment controlled by "*large teams of experts (who) voted in consensus on whether patients could continue in the process or be rejected at each stage*" (Marrow, 2023, p. 219). These older services focused on extensive assessments, intrusive questioning on sexual histories and fantasies, and collection of childhood histories "*so detailed as to specifically include habits such as nail biting*" (Marrow, 2023, p. 219). Assessments were mandatory components of access to healthcare, with healthcare provision based on coercion, "*dubious consent, and humiliating research practices*" (Marrow, 2023, p. 220). Non-affirmative trans healthcare services are widely associated with harm, with "*many people experienc(ing) clinical treatment practices as unhelpful, indeed painful, damaging and traumatic*" (Latham, 2017, p. 41). Harmful clinical practices of intimidation and trauma continue to be reported in non-affirmative children's gender services, including in the UK (Carlile et al., 2021; Horton, 2022b; Stepney et al., 2025).

Recognizing trans healthcare's association with practices of control, pathologisation and medical violence, makes it all the more important to center service users in the design and evaluation of healthcare services (Horton, 2024; Jacobsen, 2024; Pearce, 2018). This is arguably even more important in children's services, where service users' power to hold clinicians to account for harmful or ineffective practice is weak or non-existent (Ansara & Hegarty, 2012; Horton et al., 2024; Jacobsen, 2024). Child, adolescent and (trans-positive) family experience-based perspectives are critical for understanding how different models of care impact on service users. This present research has been designed to focus on a cohort with

experience in multiple trans healthcare services, both affirmative and non-affirmative, enabling a comparison between different models of care. This mixed experience enables interviewees to share reflections and insights into the strengths, harms, and impacts of different healthcare services for trans children and young people.

Across this article the following definition of affirmative versus non-affirmative healthcare provision will be used. Affirmative care is here understood as healthcare provision where a trans person's identity is embraced and affirmed by medical professionals without challenge, identity questioning or problematization, where a right to self-define one's identity is respected, and where services support access to affirmative healthcare including reversible pubertal suppression and hormones. Non-affirmative care is here understood as healthcare provision where a trans person's identity or gender history is scrutinized, questioned or problematized, where their right to self-define their identity is not emphasized, and where routes to affirmative healthcare are restricted.

UK context and current study

This research takes place at a time of significant upheaval in trans youth healthcare in the UK. Before 2024, all trans under 18s seeking publicly funded trans healthcare across England and Wales accessed one monopoly clinic, the Gender Identity Development Service (GIDS), at the Tavistock National Health Service (NHS) mental health trust (Stepney et al., 2025). The GIDS service operated as a non-affirmative service, with significant emphasis on forced identity exploration and psychoanalysis (Carlile et al., 2021; Horton, 2023; Stepney et al., 2025). Trans children and families seeking affirmative care were forced abroad, or to affirmative private sector providers like Gender GP (established in 2015) and Anne Health (established in 2024) (Kennedy, 2025; Stepney et al., 2025). Healthcare access through the NHS tightened significantly following a series of anti-trans legal cases from 2018 onwards, (*Bell*

vs Tavistock, 2020; *Bell vs Tavistock*, 2021), pushing more families into the private sector (Kennedy, 2025; Stepney et al., 2025). Amidst growing media fear mongering about trans children's healthcare, in 2020 the Conservative Government launched the Cass Review into children's gender services, that delivered a final report in March 2024 (Cass Review, 2024).

The Cass Review has been extensively critiqued by healthcare professionals, scholars, service users and trans communities, and is considered an exemplar in policy-based evidence-making (Gawlik-Starzyk et al., 2025; Giordano, 2025; Horton, 2025; McNamara et al., 2024; Moore et al., 2025; Noone et al., 2025; Pearce, 2024; Xian et al., 2025). Cass Review recommendations led to the closure of the GIDS clinic, to be replaced by a new Children and Young People's Gender Service (CYPGS) that focuses on non-affirmative exploration and investigation of a child's identity (Cass Review, 2024).

The 2024 NHS service specification guiding the new CYPGS describes a need for "*careful exploration*" of the link between '*gender incongruence*' and "*co-existing mental health, neuro-developmental and/or personal, family or social complexities in (children's) lives*" (NHS England, 2024, p. 2). The same service specification cautions about the potential harms of social transition, putting conditions on when social transition can be supported, and defining it as a decision in need of clinical approval and oversight (NHS England, 2024, p. 13). The service describes a "*watchful approach*", a synonym for delayed transition (Ashley, 2019c; Horton, 2022a), itself recognized as a conversive approach (UN Human Rights Council, 2020). Clinic training materials emphasize "*a developmental approach*", that consists of a clinician observing, questioning and monitoring a child's perception of gender before considering any support for a child's identity (Academy of Medical Royal Colleges, 2023). The service prioritizes a "*comprehensive biopsychosocial assessment*" that encompasses in-depth questioning across biological, psychological, social and developmental domains, being tasked with development

of a deep "*understanding of how the young person feels and thinks about things and their passions and their interests*" (Academy of Medical Royal Colleges, 2023, p. 41).

Affirmative endocrine care is not a core part of the new service, with reversible pubertal suppression only accessible through a Randomized Control Trial (RCT) that has still not launched 18 months after the CYPGS opened. The planned RCT has been widely critiqued and condemned as unethical, harmful, ill-suited to trans healthcare and likely to fail to meet even its own objectives (Ashley et al., 2024; Giordano, 2025; PATHA, 2025; TGEU, 2025). Barriers to NHS endocrine care were then combined, in May 2024, with a criminal ban on access to puberty blockers from private providers, closing and criminalizing the only access route to endocrine care for trans under 16s (Kennedy, 2025). The terms of the legal ban included a clause to prevent medical detransition of those already on privately-prescribed blockers—those individuals could legally continue care if their care was taken over by an NHS General Practitioner (GP).

In practice, only one NHS GP practice in the whole of the UK agreed to continue healthcare for this cohort, the WellBN GP surgery in Brighton, who adopted the care of trans young people from around Great Britain. This present research focuses on adolescents and families who received affirmative healthcare from the WellBN NHS GP practice. This cohort was selected for having experience with a diverse range of different service providers. Interviewees had experience of affirmative healthcare provision through an affirmative NHS GP, and through affirmative private sector provision. They also had experience of non-affirmative healthcare provision, through the NHS GIDS clinic pre-March 2024, and through the new NHS CYPGS post March 2024. This unique combination of experience provides valuable insight into how different models of care impact on trans children and their families. This cohort is ideally suited for addressing the two research questions (RQs) prioritized in this present study:

RQ1: What are trans child/adolescent and family experiences of different healthcare services in the UK?

RQ2: What strengths and harms are associated with affirmative and non-affirmative approaches to healthcare provision?

Materials and methods

Study design

20 interviews were conducted, with trans adolescents and their families. The sample focused on trans adolescents and families who were receiving trans healthcare through an NHS GP following the introduction of the 2024 criminal ban on puberty blockers. The inclusion criteria was being a trans child/adolescent or parent/carer of a trans child/adolescent aged 10–15 receiving trans healthcare from an affirmative GP in the UK. This sample was targeted for experience engaging with an affirmative NHS service for trans youth, in all cases the WellBN GP practice in Brighton. The sample was sourced through advertising in closed parent/carer support groups (of which the researcher is a member). The sample also had diverse experiences with other healthcare services, including NHS children's gender clinics, as described further below, with this article exploring the sample's experiences in affirmative and non-affirmative services. Research participants received a project information sheet in advance, outlining the purpose of the research, their rights, and how their data would be used, with one version tailored for adolescents.

Participants

The sample comprised six trans adolescents and 14 parents/carers of trans adolescents. Parent/carer interviewees were mostly cis women (12) with two cis men, who were parent/carers to 14

trans adolescents (10 trans girls, three trans boys, one non-binary young person) aged 11–15 years (mean 13.5 years old). Adolescent interviewees included five girls and one non-binary adolescent aged 13–15 years old (mean 13.7). All interviewees were white. From the 14 parent/carer interviews, in terms of affirmative healthcare, 14 had experience accessing trans adolescent healthcare from an affirmative NHS GP, and 11 had experienced an affirmative private provider (encompassing three different providers). In terms of non-affirmative healthcare, six had attended the older non-affirmative NHS children's gender clinic (GIDS at the Tavistock), six had attended full in-person assessment appointments at new non-affirmative NHS children's gender clinics (CYPGS), four had engaged with clinicians from the new non-affirmative gender clinics without attending an in-person appointment, and four were still on a waiting list for new gender clinics. From the six adolescent interviewees, six had accessed trans healthcare from an affirmative NHS GP, six had experienced an affirmative private provider (encompassing two different providers), three had attended the older non-affirmative gender clinic (GIDS at the Tavistock), three had attended new gender clinics, two had decided not to attend in-person appointments at new gender clinics and one had chosen not to be referred to the new clinic.

Interviews

Interviewees were asked about their experiences of different trans healthcare services, including NHS gender clinics, primary healthcare through an affirmative GP, and private healthcare services. Semi-structured interviews focused on broad open questions about service user experience and perspectives, including questions about 'What healthcare services have you engaged with?', 'What was your experience?', 'How did you find the appointments?', 'Were there any aspects that you found helpful or difficult?'. Interviews were conducted remotely using GoogleMeet in September

and October 2025. Parent/carer interviews lasted an average of 42 min (range 23–62 min). Adolescent interviews lasted an average of 20 min (range 12–24 min). Interviewed parents/carers provided written informed consent. Interviewed adolescents provided verbal assent in addition to parent/carer written informed consent. Adolescents were informed in advance of the interview that they had an option to be interviewed with or without a parent/carer, with these options discussed at the start of the interview. Two adolescents preferred to have a parent/carer remain in the room while they were interviewed. This research was not funded and interviewees were not compensated for their participation. Interviews were audio recorded with participant consent. Transcripts were produced with support from GoogleMeet transcription, with interviewer review, quality checking and anonymization, and uploaded into Nvivo for analysis.

Positionality, ethics and analysis

The research received ethics approval through the author's university, building in best practices on ethical research with trans communities, avoiding pathologisation and respecting trans identities and experiences (Bauer et al., 2019). Transcripts were analyzed using reflexive thematic analysis, an approach suited to exploratory research (Braun & Clarke, 2021). The researcher is trans and a parent of a trans child, factors known by all interviewees, providing an effective insider–outsider position from which to listen to the voices of those with relevant lived experience (Dwyer & Buckle, 2009). The researcher is a member of some of the parent support networks where the research was advertised. In reflexive thematic analysis, researcher knowledge and positionality is valued as a resource to enrich analysis, prioritizing "*reflexive and thoughtful engagement with the data*" (Braun & Clarke, 2019, p. 594). A key principle was to reflect interviewee accounts "*as faithfully as possible*", while prioritizing data that most meaningfully answer the

study's research question and "*acknowledging and embracing the reflexive influence of my interpretations as the researcher*" (Byrne, 2022, p. 4). The research was informed by critical realist epistemology, with an experiential orientation to data. This approach centers interviewees' own accounts of their experiences, in keeping with the study's exploratory research questions. The research was framed within a feminist standpoint (Brooks, 2007), centering the views, experiences and insights of trans adolescents and their caregivers. Significant attention was given to interviewee anonymity, avoiding pseudonyms and not linking adolescent age or gender to specific quotes, to protect against patchwork identification (identification from stitching together pieces of individually anonymized data). This particular cohort places a high level of importance on privacy and safety and a strong duty of care was upheld to respecting interviewee preferences in how their data were shared. An ethical commitment is upheld to centering and directly including a larger than standard quantity of quotations, recognizing that erasure and misrepresentation of trans voices is an ongoing component of anti-trans oppression, and noting the significant barriers to many trans adolescents and families having their voices heard.

Results

In this article three key themes are highlighted that capture important differences between experiences in non-affirmative and affirmative healthcare services, corresponding to 'identity probing', 'uncomfortable questioning' and 'asserting power'.

Theme 1: Identity probing: "it's like they're testing counterfeit money"

A range of parent/carer interviewees asked clinicians in the new service to describe the care being offered, and found their

explanation focused on probing identity. One parent was told there was a mandatory requirement for their young adolescent to participate in group therapy sessions focused on identity exploration. They were concerned about clinically mandated identity exploration for a child with no desire or need to explore their identity commenting "*why would I put my daughter into a room with other people… to then question and explore her gender?… it doesn't make any sense at all because [adolescent] is clear in what her gender is*".

Several parent/carers were concerned that clinicians in the new service did not support trans identities, with one commenting "*I just felt like he [clinician in new service] doesn't believe that trans people exist*". Parent/carers felt the model of care being offered by the new CYPGS was conversive, with a parent describing the gender clinic approach post Cass Review as "*conversion therapy under a different name"*, expressing concern about the offer of "*gender identity exploration therapy"*. Families offered "*exploratory therapy*" were concerned it was "*very probing and dismantling of somebody's identity and what they believe about themselves",* an approach that they feared would be *"damaging*".

After speaking with clinicians in the new service one parent felt "*that not only would our child not be believed and affirmed, but they would actively be harmed in that environment*". Parent/carers felt that being put into any situation where a child's gender was being questioned was harmful, something that "*introduces shame*". One parent felt that excessive questioning about identity was worsening mental health:

> I think it's dangerous for trans people's mental health to have to explain and justify to the extent that they're expecting of who they are. Can you imagine asking the same amount of questions that gender clinics ask to a cisgender person to get them to justify and explain why they are cisgender?.

Interviewed parent/carers felt strongly that clinicians should not be

challenging their children on their identity with one stating "*being trans is self-determined. No one knows themselves better than the person whose identity it is"*. After extensive questioning, one parent shared that their young person "*refused to answer any of their questions. She did say, 'I don't see why I have to keep justifying my existence to people all the time'*". Talk therapy to investigate whether a child is trans was felt to be an abusive offer to give to a trans child:

> They were suggesting we go down and do group sessions with loads of other trans children and discuss whether [adolescent] is even trans. We were like we don't really want to put our daughter through that. It was just going to put a lot of distress on [her]. The process they were going to take her through was a lot of poking around and challenging her as to whether she was even transgender.

Parent/carers were very concerned about the harm of a non-affirmative service scrutinizing and questioning children on their identity.

> When you're questioning your child from a position that questions whether trans identity even exists, which is what we're seeing in the refusal to use the term trans… Somebody is going to sit in a room and question my child on her own—if they don't truly believe that trans identity exists, my child is not safe to be in that room.

A young adolescent who had been through years of identity questioning in the older service, and did not want to engage with further identity questioning in the new service, reflected on the harms of a non-affirmative approach.

> I would have liked them to believe I was a woman and not having to make me prove it to them over two years…. I'd like them to just be so much more gender affirming rather than gender questioning cos it's like the 'gender identity development services'. I'm not developing my gender identity, I've had that since I was 4 years old.

They reflected on the absurdity of having their identity diagnosed:

> Two years into my experience there they were like okay we think you are transgender. I was like, no darlings, I've come here because I am transgender….(the clinicians declared) 'we deem you a woman'. And I was like, what?… Every session they were like, "How do you feel in terms of gender?… It was so difficult cos they just asked the same question over and over again.

They found the interrogative questioning of identity emotionally very distressing:

> It was always the same questions phrased differently and it felt like they were trying to catch you out… It's like they think of trans people as fraudulent. It's like they're testing counterfeit money.

One parent had declined their invite to the new service as soon as they reached the top of the waiting list, concerned about the focus on identity exploration.

> The time we actually did get a referral there was no way I was putting my young person in that environment because she was flourishing and thriving as a trans person… why would we go back to just talk about her being trans—there would be nothing to be achieved by that but there would be a great deal of damage potentially. So, I just don't trust—none of us trust that system would do anything beneficial to her. But we do fear there would be harm. There's a hostility underlying it… so I feel she wouldn't be safe. I actually feel she wouldn't be safe. Yeah. Which is an awful thing to say.

The non-affirmative approach to identity probing seen in the specialist gender clinics contrasted strongly with the approach experienced in an affirmative primary care service. Families reflected on how meaningful it was for their child to be in a room with a professional who accepted their transness. One parent commented that "y*ou could sort of see the stress draining off her… the experience that was so validating… because he [Affirmative GP] validated her identity*".

One family contrasted having been through extended assessment

in the older children's gender clinic without their child ever having their identity affirmed, to the experience of having a professional quickly accept and support their identity.

> He was very clear with her, you're trans and you get to say that, nobody else gets to decide that. And [adolescent] was… very vocal in that appointment about their experience of the Tavistock and how difficult that had been. We saw the Tavistock 18 months and at no point did they say you're trans and that's fine. Whereas [affirmative GP] within about 5 minutes said I trust you—you're the person with the information about your body and what you need. Which was revolutionary.

Some parent/carers had had experience with affirmative private sector healthcare providers, commenting on the benefits of an affirmative approach that did not scrutinize or question identity:

> That was good because they weren't bringing into doubt my daughter's gender. They didn't act like they disbelieved her. They weren't asking questions which made her think they didn't believe her. They asked questions in order to get to know her and to make sure that she could make informed consent and what her expectations were with gender affirming care. What is it that she wanted? What results did she want? Why did she want that gender affirming care? What did she know? What does she want to know about it? and how is she feeling with her gender dysphoria? Talk about her feelings in general. So, it was supportive.

They contrasted affirmative counseling through a private provider with what they had experienced in a non-affirming gender clinic:

> The counselling sessions (at the private provider) were really good… my child has felt quite comfortable and able to open up and talk to them because it's been a gender affirming model. So, my child doesn't feel like they're being judged. They don't feel like they have to prove themselves in order to gain access to care. They can just be themselves and let them know who they are. And that's made a big difference.

Theme 2: Uncomfortable questioning: "they want a documentary on your life"

All who had attended the new NHS CYP's gender service described their child being questioned by multiple adults. One parent described an intimidating panel of professionals, "*a pediatrician, the social worker, and then a psychologist…someone else as well. All of them had notebooks and were scribbling down everything that we said*". Another parent described the experience as being awful and overwhelming:

> We had a face-to-face appointment in London, and I've had a couple of online appointments… It was awful… I think I ended up in tears for a lot of it. It was very overwhelming. There were five people there, a paediatrician, a youth worker. There was a psychiatrist, there was a safeguarding officer or something like that. And I can't remember what the fifth person was.

Parent/carers felt that the set-up of the gender clinic interviews, against a panel of 4–5 adults was particularly intimidating and unfriendly.

> It would be traumatic for anyone… Even if it was five people, multidisciplinary team, that were gender affirming and fully supportive…. It would be intimidating to be up against five people you didn't know asking multiple different questions of a very personal nature.

A young person commented on feeling uncomfortable in their sessions at the new gender service, being asked questions by a panel of multiple professionals:

> I had to sit in a room and talk to five different people at the same time and I just kind of had them all watching me… just in a room with five people. I don't remember the questions they asked, but I definitely remember feeling very uncomfortable the whole time… it's generally invasive and really they just don't show any care to

> how you feel about answering the questions… it feels like all the spotlight's on you and it's not a good feeling.

Parent/carers and young people felt the questions asked by the gender service were inappropriate. A parent commented "*I think the questions are intrusive, unnecessary. I think they are deeply personal and irrelevant*". A young person described being given "*a horribly invasive questionnaire the first time I went there*". Another young person described their experience being asked lots of questions in the new gender service:

> They were asking just questions about my home life and stuff and my personal life. I feel like most of the questions ended up being about my personal life rather than, the whole transgender thing… I was kind of uncomfortable with the amount of questions. They did ask a few questions about my relationship with my parents, as if they were questioning it. And I just feel like they were overall just really asking about my personal life and my relationships and stuff, which I feel like had nothing to do with what we were there for.

Several parent/carers described their young people as being uncomfortable and anxious when visiting the new gender clinics, which was exacerbated by pressure from the service to be interviewed away from their parent/carer. One young adolescent shared their feeling of not wanting to be separated from their parent:

> I feel like if I'm in a new place, my anxiety's very bad. So, I like my mum being with me, but I feel like if they're asking questions like that with my mum, also I didn't know what they would ask me or try to ask me if my mum wasn't there. So, I was just kind of like—I didn't do it.

Another parent described their child's reaction to gender clinic questioning:

> Then they separated us… She's like, why am I going through this with these people that I don't really know? Cos every time you go,

> they change…. And they always ask the same questions and they're really weird questions.

Children who had been questioned at extended length without a parent present shared that they felt they had been asked "*really stupid questions"*. Another parent described having attended a 4-h appointment:

> I remember it being too formal… we were under a microscope. It wasn't friendly. It wasn't nice. It was just a group of people sat there asking questions…They just kept asking [adolescent] how he feels about puberty and stuff. And I thought if he's answered it once… he was quite shy and he didn't really want to speak about it because he doesn't like speaking about it.

A young person who had attended sessions at the new gender service described it as "*probably the worst thing I've ever experienced*". Families emphasized the quantity of inappropriate questions they were being asked, that one parent described as "*a barrage of questions"*. Another parent felt their parenting was being probed, looking for negative parental influence on a child's identity:

> We were there in total three hours… It was just really weird. They were there to judge me. They were there to try and find out what they could about me and how I've brought [adolescent] up, and whether I've made her be like this. I felt like it was all questions about [adolescent]'s life, like right from pregnancy right up until that current point, but it wasn't questions about what could help them. It was all probing questions, really. I don't like confrontation, and I was petrified being there anyway, and I should have called them out on asking questions like that… but didn't have the confidence with all those people.

A young person, who didn't want to be asked invasive questions in the new service, reflected on their experience being asked incessant questions in the older GIDS.

> They did ask a lot of useless questions. And I think there was a lot of

> focus on things that weren't related to my gender dysphoria… They apparently just want a documentary on your life… which just doesn't feel very useful to me. I think the important parts are the parts relating to my gender dysphoria, not my interests and hobbies, if those aren't connected to any moment that kind of showed gender dysphoria.

The most positive reported experience at the new gender service was from a parent who found the experience unharmful, whilst also unhelpful, and not worth the time (lost days of school and work) and expense (£200 for peak time train travel).

> It was just… talking about the history and telling them everything that we've done. There were no leading questions. There were no judgmental type looks or anything. It felt okay… Then the third session again…the person leading that was like, right, let's write a timeline. We were again just dumping loads of information on them.

On reflection they saw no benefit to the sessions, that seemed designed purely to collect data to write a comprehensive report, that seemed to be without purpose.

> I don't think these sessions have been to benefit us at all. I think these sessions have been pretty much for the benefit of them…I think that it's literally being written into a file and then the file's being put into a cupboard.

Asked why they were attending a service that wasn't helpful for them, they responded that they were engaging as a defensive strategy, in case their family was investigated for failure to engage. Several parent/carers felt regret afterwards that they had attended sessions in new gender clinics that they felt had been harmful for their young person:

> I feel really guilty that I went into that service. I've been really naïve, I think, about the whole thing. I naïvely believed that these people were there to help us.

Several parent/carers had asked to be discharged from the new service, with one telling their clinician *"it's not a safe place for us to come"*. One parent had put off attending their scheduled in-person appointment, feeling their child had already been through too much questioning in the older gender service:

> I want no part of the new gender service. It's toxic and dangerous for our kids and my kid cannot cope with any more of the sort of assessment and discussion that we've experienced thus far, and I will not put them through it. It's so damaging to their mental health.

A young person contrasted their experience of uncomfortable questioning in a non-affirmative gender clinic with feeling cared for in an affirmative service.

> I feel they [non-affirmative service] just asked questions, not really caring if it made me uncomfortable or not. Whereas [affirmative GP] he makes sure I'm okay with answering it.

Interviewees reflected upon a very different approach to being questioned within affirmative services. One parent commented that "*I think she probably trusted [affirmative GP] more because he was trans —That first appointment was extraordinary because [adolescent], I think, felt seen for the first time, felt heard… and I felt like he was asking questions that were pertinent*". Several parents felt that an affirmative service created a safe space where trans adolescents could speak honestly about their feelings and their worries. One parent described seeing their child open-up more in one affirmative appointment, than in 2 years in a non-affirming service:

> I was just quite blown away. I was like, Wow. We sat in that office for 45 minutes. I came out like almost puzzled. I'm like years. I was almost ** angry when I left, about the Tavistock again. In f****** years. Never once has somebody sat down and talked to my daughter like that, like she's a person and it's not an interrogation. It's just a holistic health approach to a trans young person. It was wonderful actually.

A young person shared a similar perspective:

> [Affirmative GP practice]'s been amazing. I wouldn't be as happy as I am now without [Dr]. I feel like… because [Dr] is trans as well, I feel more understood in a sense. It was really calm, I'd say. I didn't feel any—Normally I'm really nervous… but I felt very calm about it. There weren't any invasive questions I feel like some people tend to ask. They were very normal, and I liked it. I think more people should have that approach cos it's really very—it puts people at ease.

They contrasted feeling at ease in an affirmative service to feeling on the defensive or unsafe in non-affirmative gender clinics.

> With the other gender service, I built a wall around myself to kind of prepare myself in a way, but I don't have to do that with [Dr.]… I can just answer the questions freely.

Theme 3: Asserting power: "I will tell you want I want – you will disregard it"

18 months on from the closure of the older GIDS clinic, many interviewees reflected upon their experience there. Amidst these reflections, the theme of powerlessness came up frequently. A young person referenced having their expected goal posts for referral to endocrine care continuously shifted, an end point that continually moved away from them, with the clinic closing-down before they were ever approved for endocrine care.

> (GIDS was) very stressful, very time consuming and frustrating… We were promised six sessions and then we'd get referred and then it was nine sessions and we hadn't gotten a referral yet. And it just felt like really obtuse and just designed to be annoying and not work, to seemingly discourage people from even trying.

Parents reflected on the lack of transparency and accountability of decision-making processes within children's gender clinics. Several focused on the operation of multidisciplinary decision-

making panels, that take decisions without patients, families, or patient representatives present, based on case notes written by clinicians, that are not even shared with families or young people. One parent, whose young person had been denied approval for endocrine care by the decision of a complex case panel in the months before GIDS closed-down, had finally been able to access their case notes after the service shut.

> I'm not kidding—I read them and I could barely speak… it was traumatizing. I was so severely gaslit by what I read about myself and my husband.

The parent was shocked to read case notes written by a clinician that bore no resemblance to the experiences that their family had shared with the clinician.

> We read it, and I was just beside myself. They used terms… 'we're a family of rescuers' 'we're a family of activists'…. It was like a witch hunt on me… He just was basically saying that I've forced being trans on my daughter, I've made her trans and that we're too influenced by the LGBT community. They were…really preoccupied with the fact that we've got an adult trans friend and that [adolescent] confides in her and talks to her. That was really problematic, and they asked me so many questions about this trans person which I also found really offensive. It's okay (if) she's talking to a cisgender person. If she's talking to a trans person, they're clearly trying to influence her. So, it was all very pathologising really.

The parent found the clinician notes biased, misrepresentative of their experience, unevidenced and judgemental. She saw misogyny in the way clinician notes critiqued the parenting of a mother and grandmother, while a father was barely mentioned despite his active co-parenting role. The parent was concerned at the inclusion of unevidenced speculation of alternative theories for why a child is trans, including their connections to LGBT communities or trans friends. These notes had directly contributed to their child being

denied access to endocrine care, without the adolescent or family knowing what was in their notes or having any opportunity to challenge them.

Several parents had been through a process of Multi-Disciplinary Team case review or complex case review panel in the last year of the old gender service before GIDS closed. They commented on the lack of transparency, accountability, and patient voice in closed decision-making processes. One parent referenced having not even been able to access the reports that were being submitted to panel about their young adolescent:

> It felt very secretive. I did ask at the time to see reports that were being sent… but I was not granted access to any of those, even though they're about my child… Seemingly these MDTs are secret, and they don't seem to put that on your file as something that you can then access.

In their case, the panel denied approval for their young person to access endocrine care. When the panel's decision was reported back to them and their young person, they were shocked at the information conveyed:

> When they came and met with us, he pretty much said that we had always been committed to a medical pathway and that we had put [adolescent] under pressure. I was really, really alarmed and really upset and angry in that moment in that meeting. I felt there was a huge power imbalance… I said to him you've known us for a few months and clearly you have not understood the case notes from two, three years because all you will see is us being on the fence for years (about medical transition)… This guy took our case to complex case panel… we can see in the notes there was a narrative that he sold to them and on the basis of that they said no.

The experience of having decisions about their healthcare made without any voice, influence, or power was very negative for the parent and their young person.

> It was a really, really traumatic experience and it's not too far

> stretched to say that it was traumatic…that was probably the worst my daughter has ever been.

A young person who had been denied approval for endocrine care by a review panel in the latter months of GIDS spoke about their experience:

> Ask me the same question you asked me the week before and then drill it into my head. No, you don't care about people. You care about 'fertility'…because I wasn't… [interviewee visibly upset]… Sorry, more anger… because they told me 'You didn't do anything wrong.' And then a week later, they sent us an email of everything I'd done wrong. The reason they did never prescribe me blockers, because I didn't display the emotional intelligence that was required for it or the Gillick competence which I actually do have.

They described their own feelings of powerlessness in a process where their own voice and opinion did not matter:

> Because I tried to tell them every session what I want. I want hormone blockers. I want a pause in my life. I want to be able to get everything in my life all right. Cus that was everything. My life was like—I'm already stressed enough. In a few years I had GCSEs. …and I didn't have a say in anything. It was always like I will tell you what I want. You will disregard it.

They reflected on their experience in their final session with GIDS before it closed-down:

> They were always very like, 'you're not displaying enough distress or gender dysphoria'… in my final session I was screaming at the guy, and I was crying, and I was like are you happy now? Cus I didn't get any empathy from him… I'm glad that the traumatising place was shut down.

Another young person described their experiences in the months before GIDS closed. They described having been forced to undergo an unwanted physical genital examination, and having been pressured to undertake fertility preservation, before then being

denied access to endocrine care by review panel:

> Distressing to say the least… I was like why do you need to examine me? I was like, 'God, it was totally unneeded'… and even there they were pressuring me (re) fertility. I was an 11 old girl. I don't care about fertility. And I kept telling them I don't want to be part of that. For me that's so dysphoric. In my personal experience, it made me feel so just like urgh.

None of the parents and young people attending the new CYPGS had yet, in the 18 months since the service opened, had their case taken to an MDT or complex case panel for access to endocrine care, with endocrine care pathways completely closed. None had yet seen any of their clinical notes or any reports from their multi-session interviews. Confidence remains very low that the service will have learnt any lessons on the above failings of the older service. Indeed, families and young people were fearful that a lack of service user power and accountability, a lack of child and adolescent voice, and a lack of respect for autonomy over healthcare decision-making were aspects that are likely to be even worse under the new service. Families felt that clinician power over children and families was stronger under the new service, with clinical decision-making structures having even weaker mechanisms for transparency and accountability.

In contrast to their experiences in non-affirmative gender clinics, interviewees described their positive experience in affirmative services. One interviewee described affirmative primary healthcare as "*a very supportive space and understanding space… (where) they operate from a position of bodily autonomy and self-determination*". Interviewees valued the emphasis on autonomy and supported decision-making in services following an informed-consent approach to trans healthcare:

> We went down to see [Dr.] and [adolescent] came out almost skipping because of the way that he was able to relate to [adolescent], to tell her that she's okay, that there's various

> treatments and different ways that he can help her.

Parents also felt less judged and more supported in an affirmative service:

> Dramatically different from any of the other gender healthcare that we've had… (than) my experience at the Tavistock, where I'd felt like revealing that I was queer or that I was a single parent or stupid stuff like I've had a home birth… [Dr. in affirmative service] was just like, 'I can see you're a really caring parent' and I felt really heard.

Another parent commented on the impact of having an affirming GP on her daughter:

> The days after (meeting with affirmative GP) saw a huge change in my daughter… there was something I think about it being an NHS GP—we should all be able to access NHS care and that's been restricted from her. And I think sitting in a GP surgery accessing her care needs with a trans doctor who was so holistic…. There was something about the way he interacted with her. I think it was his level of lived experience and insight that came across to her. I think it was really empowering for her.

Interviewed parents felt strongly that an affirmative model of care was the best approach for their children.

> The gender affirming model and informed consent model is the healthiest and safest way for trans youth and trans people no matter what age… England is an outlier in following the discredited Cass review… I've had a very happy child who's had a happy childhood because they know that they're not forced on any path. They know they're free to be who they want to be, even if that changes and evolves.

Affirmative primary healthcare provision was something that interviewees would like to see more of, receiving affirmative care close to home. A trans young person shared their perspective on how NHS trans adolescent healthcare should work, emphasizing the

importance of respecting individual autonomy and supported healthcare decision making.

> I'd like it to be a service where people feel like they are treated humanly—given the treatment they need off their own autonomy… when they are deemed (ready for healthcare) by themselves.

Discussion

The first theme focuses on differing approaches to identity in affirmative and non-affirmative services. In affirmative services, identity is respected without probing, without forcing a child to explain and defend themselves, with transness accepted as a non-problematic part of human diversity that does not need to be a topic of clinical concern. Interviewees who had experienced clinical scrutiny in NHS gender clinics found it '*revolutionary*' to have a trans adolescent's identity recognized without challenge by an affirmative GP. Interviewed adolescents described how upsetting it was to have to prove, justify, and defend their identity in non-affirmative NHS gender clinics. This theme corresponds directly to scholarship on pathologisation and clinical domination over trans patients (Suess Schwend, 2020). Writing on the power that medical establishments wield over trans identities, Jacobsen (2024, p. 2) describes how "*a legacy of psychopathologising transness casts undue suspicion over trans people's self-knowledge and grants clinicians the epistemic power to (dis)believe trans people's asserted gender identity*". One interviewed parent commented on having experienced two completely different healthcare paradigms "*either trans exists or it doesn't exist*". They felt strongly that safe and effective healthcare was completely incompatible with non-affirmative approaches that regard transness with suspicion or as a clinically significant problem in need of investigation.

The second theme focuses on the inappropriate questioning that appears intrinsic to a non-affirmative approach. Interviewees felt under scrutiny, judged, invaded and uncomfortable while being

questioned by panels of professionals in NHS children's gender clinics. This finding reinforces existing literature critiquing gender clinics for imposition of an approach grounded in extensive and elaborate assessment "*without evidence that this results in better outcomes and without consideration of the costs to trans people*" (Latham, 2017, p. 45). It is noted that the questions asked within gender clinic assessments are in addition to a significant research burden placed on trans youth. A recently published NHS research protocol for the 'non-intensive' wing of a CYPGS clinical study (Simonoff & Absoud, 2025), outlined 314 different questions that will be asked of trans youth, including questions that can be regarded as pathologising and inappropriate.

Core to a non-affirmative approach is an externally imposed agenda—questions are focused on the concerns or curiosities of a clinician, without centering or respecting the topics that service users are concerned about or want to explore (Ashley, 2019a). According to Jacobsen (2024, p. 5) "*the logic of requiring mental health assessments for gender-affirming care is inextricable from the historical pathologization of transness*". Young adolescents who had experienced affirmative healthcare provision, including from an NHS GP, spoke of feeling relaxed and secure in clinical encounters where they were not asked questions that felt strange, triggering or inappropriate. This was critical to building rapport and trust, enabling young people to feel safe and supported enough to engage in meaningful conversations about their life challenges, worries, and healthcare needs.

This finding reinforces existing scholarship by Ashley (2019b) who argues that gender affirmation is a necessary foundation for clinical trust, with trust essential for meaningful exploration of an individual's healthcare or support needs. It aligns with scholarship from authors including Latham (2017, p. 54) who maintain that "*a pre-condition of psychiatric approval precludes the very possibility of 'psychological support', setting up a relationship where patients must prove themselves worthy of treatment*". For Latham and other trans

healthcare scholars, a gatekeeper holding authority for assessment and approval in a non-affirmative service can never be source of genuine and trust-worthy psychological support, a view reinforced by interviewed adolescents and families.

The third theme focused on power and autonomy. At a distance of 18 months post the closure of the older GIDS service, interviewees reflected on their feelings of powerlessness within that service. Non-affirmative services, by definition, do not center a trans young person's perspective, and this fundamental rejection of patient autonomy is seen across the wider design and functioning of these services. Adolescents spoke of having their voices and requests for care ignored and over-ruled. Interviewees spoke of an absence of mechanisms for holding services to account for their harms. Interviewees spoke about a total lack of patient control in clinical decision making, including in case review panels, where decisions were taken without patient advocacy or representation. Parents spoke of being denied access to the notes and reports upon which decisions were made, and being unable to challenge inaccurate clinician accounts or clinician-imposed judgements, including where clinician commentary or interpretation directly contradicted service user testimony. This theme of patient powerlessness has been a mainstay of historic approaches to trans healthcare (Marrow, 2024; Pearce, 2018). Jacobsen (2024, p. 1) notes that an assessment-based model of care "*prioritizes the clinician's expertise and authority over the trans individual's desires or lived experiences*" entrenching medical authority over trans lives.

Interviewees contrasted their powerlessness in NHS gender clinics with feeling empowered and having their autonomy and rights recognized in affirmative services. Affirmative services actively prioritized patient autonomy, regarding their clinical role as one of providing information, advice and support from which patients could make their own informed decisions. This informed-consent approach to trans healthcare was strongly endorsed by all interviewees. Indeed, this cohort, who had experienced affirmative

primary care-based trans healthcare from a GP, all spoke extremely highly of that care, wanted it to continue, and wanted to see this model expanded across the UK. At time of writing, however, GP led trans healthcare is under significant pressure from NHS England, with ongoing threats to close affirmative primary care services for trans young people.

Implications

This research highlights significant concerns, harms, and failings of non-affirmative healthcare services. Many of these harms and failings are inherent to a such a service, core to its functioning, and unlikely to be ameliorated while continuing a commitment to non-affirmative approaches. Healthcare managers and decision makers, including politicians, need to understand a reality that harms are baked into non-affirmative models of care. This research highlights several benefits, and high patient satisfaction rates with affirmative healthcare provision, including in NHS primary care, demonstrating that a better, less harmful model of care is possible. What is missing is the political will, across and beyond the NHS, to uphold trans rights and child rights (Horton and Pearce, 2025), and to shift healthcare resources into affirmative provision.

Limitations and directions for future research

This exploratory research provides qualitative insights into the experiences of trans adolescents and families in different healthcare services. The key themes from this research, related to patient satisfaction with care; experiences of inappropriate, invasive and uncomfortable questions; experiences of extensive and interrogative questioning; probing and needing to justify one's identity; and powerlessness vs autonomy, can all be explored through larger scale

quantitative research. These components should certainly be embedded into the metrics for monitoring and evaluating current providers of trans healthcare services, ensuring services are held accountable to aspects of care that matter to service users.

This research focused on a specific sample of families who had been able to navigate across different healthcare providers to arrive at an affirmative NHS GP. This cohort is more likely to include adolescents with supportive families. Indeed, all interviewed parent/carer interviewees were supportive of their young person and all interviewed adolescents had at least one supportive parent/carer. The views and perspectives of multiply-marginalised trans youth without parental support were not included here, nor were perspectives from trans youth of color.

Conclusion

This research highlighted three significant differences between affirmative and non-affirmative care, related to identity probing, uncomfortable questioning, and asserting power. This article provides lived experience perspectives on the harms and failings in non-affirmative healthcare provision in NHS children's gender clinics in the UK. It also provides lived experience insight on the benefits and strengths of affirmative healthcare provision, that were unanimously desired and found beneficial by those interviewed.

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Ethical approval

All procedures performed in studies involving human participants were in accordance with the ethical standards of the institutional and/or national research committee and with the 1964 Helsinki declaration and its later amendments or comparable ethical.

Informed consent

Informed consent was obtained from all individual participants included in the study.

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